Documentation of Medical Necessity for the Provision of Contact Lenses

(This form is to be completed and attached to DCH-0893 when requesting prior authorization for the provision of contact lenses. Prior authorization is NOT required for beneficiaries with congenital or surgical aphakia who are under six years of age.).

Beneficiary's Name _____ **Medicaid ID Number** _____

Indicate the diagnosis(es) which best describes the beneficiary's condition:

- ☐ Aphakia (congenital or surgical)
- ☐ Keratoconus (if vision cannot be improved to 20/40 or better with eyeglasses)
- ☐ Anisometropia or antimetropia (of 2 diopters or greater that results in aniseikonia)
- ☐ Congenital cataracts (up to six years of age)
- ☐ Other conditions with no alternative treatment (Explain)

_____

_____

Diagnosis(es) (ICD-9-CM): _____

Current spectacle correction:				**Best spectacle correction:**			
R	_____	**VA**	_____	**R**	_____	**VA**	_____
L	_____	**VA**	_____	**L**	_____	**VA**	_____
ADD	_____			**ADD**	_____		

Has the beneficiary previously worn contact lenses? ☐ YES ☐ NO
If yes, explain:

_____

_____

Is the beneficiary currently wearing contact lenses? ☐ YES ☐ NO
If yes, indicate reason for new lenses:

_____

_____

Keratometry (diopters)

R _____ @ _____ ; _____ @ _____

L _____ @ _____ ; _____ @ _____

Type of contact lens requested:

A. Hydrogels

	R	L
Power		
Series (Brand Name)		
Additional Specifications		
Manufacturer		
Manufacturer's wholesale cost		

B. Rigid Gas Permeable

	R	L
Base Curve		
Power		
Diameter		
Additional Specifications		
Manufacturer		
Brand Name		
Manufacturer's wholesale cost		

Expected obtainable visual acuity with contact lenses at distance:

R _____ **L** _____

Approximate wearing time per day (specify number of hours):_____

Are eyeglasses to be worn simultaneously, as an over-correction, with the contact lenses? ☐ Yes ☐ No

Provide your assessment of beneficiary's ability to insert, remove, maintain, and wear contact lenses:

_____

_____

_____

_____ _____

Provider's Signature **Provider's Name (Print)**

Date: _____